Plan of Care/Needs Assessment

Monitor this record on a monthly basis to track the status of the participant's needs. New/updated goals must be recorded in the database quarterly, as well as any changes to current goals. Update the status of all goals at discharge.

Client ID: _____

Admission ID: _____

Client Name: _____ Birth Date: ____/____/____ Medicaid ID # _____

Agency Assigned: _____ Subcontractor: _____

Need Category **1** parenting skills family practices **2** Living situation **3** Medical needs substance abuse **4** Home safety **5** Financial situation 6 Transportation **7** Emotional/psychosocial Needs 8 Dental Needs	**Date Identified**	**Goals** (text)	**Goal Status** **P** progress **N** no progress **C** changed **M** met	**If Changed Or No Progress, Reason** **N** services not available **S** participant left service **P** personal choice **I** ineligible **T** transportation issue **C** childcare issue **L** language barrier	**Action Steps** (text)	**Referral** (use codes below)	**Referral Mode** 1 appointment made 2 brochure information 3 escorted to referral site 4 discussion recommendation	**Action Status** **C** Completed **I** In process **D** Dropped
1								
2								
3								
4								

Referral Codes:

01- back to referrant	26- DHS	10- HIV/STD testing	15- nutrition counseling	20- substance abuse counseling
02- childcare resources	27- domestic violence counseling/assistance	11- housing assistance	16- parenting education	21- transportation resources
03- child health clinic	25- Early Intervention Program	12- income maintenance	17- private insurance	22- WIC
04- child welfare	07- education resources	13- job or job training /assistance	18- shelter	23- unknown
05- clothing agencies	08- family planning	14- medical services/medical home	28- smoking cessation program	24- other
06- dental services	09- food pantry	29- mental health counseling	19- Stork's Nest/incentive program/thrift shop	